BELLE MEAD DENTAL GROUP
MARK T. LUBITZ, D.M.D.
2230 Route 206
Belle Mead, NJ 08502
Ph: (908) 874-5100 Fax: (908) 874-0921

WELCOME TO THE BELLE MEAD DENTAL GROUP

In order to best serve the needs of our patients, the following policies have been established.

Appointments: We try our best to accommodate your scheduling needs and we have set aside time just for you. Please give our office at least 24 hours notice if you are unable to keep your appointment. You will be charged for broken appointments if proper notice is not given.

Payment: Payment is due at the time services are rendered unless prior arrangements have been approved. We accept Visa, MasterCard, Discover and American Express for your convenience.

Insurance Billing: As a courtesy to our patients, we will submit your insurance claims, or if you prefer, provide you with the necessary information to file a claim. Please understand that we are a third party in submitting your insurance and the insurance company is responsible to you for services that they cover.

Know your Benefits Coverage and Limitations: All after insurance balances will be the patient's responsibility. We will accept assignment of benefits on your insurance, but the estimated patient portion of your bill will be due at the time of service. ** A late fee/processing charge of 1.5% per month will be applied to accounts 120 days past due.

Collections: If it should become necessary to send a past due account to a collection agency, the patient will be responsible for all collection fees incurred, including interest of 1.5% per month and 33% attorney fees.

Your signature of benefits in order to process your insurance claims. By signing this consent form, I am giving my consent to use & disclose my health information to carry out treatment, payment, and healthcare operations.

We look forward to providing the highest quality of service to you and your family.

Patient Signature_____ Date: _____

PLEASE READ AND SIGN ALL ATTACHED PAGES AS REQUIRED BY LAW

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ _____ _____ _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person responsible for account _____ _____ _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.